



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Doctors Hospital at Renaissance

**Respondent Name**

Texas Mutual Insurance

**MFDR Tracking Number**

M4-17-3249-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 6, 2017

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

**Amount in Dispute:** \$720.81

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "One year from disputed date 7/1/16 is 7/1/17. The TDI/DWC date stamp lists the received date as 7/6/17 on the requestor's DWC-60 packet, a date greater than one year from 7/1/16. The requestor has waived its right to DWC MDR."

**Response Submitted by:** Texas Mutual Insurance

### SUMMARY OF FINDINGS

| Dates of Service  | Disputed Services         | Amount In Dispute | Amount Due |
|-------------------|---------------------------|-------------------|------------|
| July 1 – 28, 2016 | Physical Therapy Services | \$720.81          | \$0.00     |

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical claims.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment

- W3 – In accordance with TDI-DWC Rule 134.804. This bill has been identified as a request for reconsideration or appeal.
- 350 – In accordance with TDI – DWC Rule 134.804, This bill has been identified as a request for reconsideration or appeal
- 356 – This outpatient allowance was based on the Medicare’s methodology (Part B) plus the Texas markup
- 420 – Supplemental payment
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- 891 – No additional payment after reconsideration

### **Issues**

1. Was the request for MFDR timely for July 1, 2016?
2. Are the insurance carrier’s reasons for reduction of payment supported?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The requestor is seeking reimbursement of Codes 97140, 97530 and 97110 for dates of service July 1, 2016.

28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is July 1, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on July 6, 2017. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division’s MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

The remaining dates of service in dispute are July 8 through July 28, 2016 for physical therapy services performed in an outpatient hospital. The insurance carrier reduced the disputed services with adjustment reason code P12 – “Workers’ compensation jurisdictional fee schedule adjustment.”

The services in dispute have status indicators of “A” or “Not paid under OPPS. Paid by MAC’s under a fee schedule or payment system other than OPPS.”

28 Texas Administrative Code §134.403 (h) states in pertinent part,

For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

Therefore, the services in dispute will be reviewed per provisions of 28 Texas Administrative Code 134.203(c)(1) which determines the reimbursement rates for professional services.

2. 28 Texas Administrative Code 134.203(c)(1) states in pertinent part,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor.)

The Medicare payment policy that effects the services in dispute is found at [www.cms.gov](http://www.cms.gov), MLN Matters Number: MM7050 which states in pertinent part,

The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings.

The maximum allowable reimbursement calculations that include the MPPR reductions are found below:

- Procedure code 97140, service date July 8, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97530, service date July 8, 2016. This code has the highest PE for this date. The first unit is paid at \$53.17.
- Procedure code 97110, service date July 8, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.
- Procedure code 97140, service date July 11, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97530, service date July 11, 2016. Payment for each subsequent unit is reduced by 50% of the practice expense. This code has the highest PE for this date. The first unit is paid at \$53.17.
- Procedure code 97110, service date July 11, 2016. Payment for each subsequent unit is reduced by 50% of the practice expense. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.
- Procedure code 97140, service date July 13, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97530, service date July 13, 2016. This code has the highest PE for this date. The first unit is paid at \$53.17.
- Procedure code 97110, service date July 13, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.
- Procedure code 97140, service date July 18, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97530, service date July 18, 2016. This code has the highest PE for this date. The first unit is paid at \$53.17.
- Procedure code 97110, service date July 18, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.
- Procedure code 97140, service date July 21, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
- Procedure code 97530, service date July 21, 2016. This code has the highest PE for this date. The first unit is paid at \$53.17.
- Procedure code 97110, service date July 21, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.

- Procedure code 97140, service date July 22, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$35.35.
  - Procedure code 97530, service date July 22, 2016. This code has the highest PE for this date. The first unit is paid at \$53.17.
  - Procedure code 97110, service date July 22, 2016. This code does not have the highest PE for this date. The PE reduced rate is \$38.00 at 2 units is \$76.00.
  - Procedure code 97004, service date July 28, 2016. This code has the highest PE for this date. The first unit is paid at \$79.98.
3. The total allowable reimbursement for the services in dispute is \$1,067.10. This amount less the amount previously paid by the insurance carrier of \$1,491.07 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

### **Authorized Signature**

|           |  |               |
|-----------|--|---------------|
| Signature | Medical Fee Dispute Resolution Officer | Date          |
|           |  | July 26, 2017 |

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim. The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**